IPM DIARY OF EVENTS

Wednesday November 18 1987, 8 p.m.
Clinical Meeting at 11 Chandos Street, London. Dr. Thexton will speak on "Whether to see one partner or both".
Supper (£10) provided if notice to Secretary by 10/11/87. Members may prefer to bring their own refreshments.

Friday March 18 1988, 4.30 p.m.
A.G.M. at 11 Chandos Street. Dr. Tunnadine will speak on "Whither psychosexual medicine?"

Friday September 23—Sunday September 25 1988
The Annual I.P.M. Scientific Meeting at Leicester University.

OTHER DATES FOR YOUR DIARY

R.S.M.

Saturday October 24 1987 at 9.30 a.m. at the R.S.M.
Forum on child sex abuse.

Monday January 25 1988 at 6 p.m. at the R.S.M.
Forum on hormone replacement therapy.

Saturday April 23 1988 at 9.30 a.m. at the R.S.M.
Forum on the quality of sexual life.

Friday July 1 1988 at 6 p.m. at the R.S.M.
S.T.D. counselling workshop.

N.A.F.P.D.

Saturday January 23 1988
Affiliated group meeting, Sheffield.

Friday/Saturday April 8/9 1988
A.G.M. Symposium, Swansea

Thursday/Friday October 6/7 1988
Wyeth current fertility.

LONDON ACCOMMODATION

CIBA Foundation, 41 Portland Place, London W1N 4BN (Tel. 01-636 9456) offer limited accommodation to doctors attending scientific meetings.

Single room + breakfast = £17-50.
Double room + breakfast = £28-00.

Early booking is essential.

Institute of Psychosexual Medicine

CONTENTS

LIST OF OFFICERS ... Inside front cover
EDITORIAL ..... page 1
Incest: The Aftermath
Report of Scientific Meeting with Dr. Brendan MacCarthy 2
To lead or not to lead
Report of Leaders Workshop 6
ARTICLES
"Getting us sorted out has helped me stick up for myself"
Dr. Barbara Devereux 7
A man with a problem
Dr. Jane Kilvington 10
Redundant
Dr. Margaret Wheatley 11
Impotence - is redundancy the cause?
Dr. Morag Bramley 13
The man who couldn't kill a mouse
Dr. Rosemarie Lincoln 14
Two terrified people
Dr. Rosemary Bradbury 16
The expert: a cautionary tale
Dr. Keith Stewart, Dr. Caroline Albiston, Dr.Sonia Robertson 18
Evaluation of Psychosexual Nurse Seminars by a group member
S. Conway, S.R.N. 23
NOTICES 25
OBITUARIES 27
IN PRESS 27
FROM THE JOURNALS 28
NEW MEMBERS & ASSOCIATES .. 29
I.P.M. TRAINING SEMINARS 30
REGIONAL TRAINING CO-ORDINATORS 31
INSTRUCTIONS TO CONTRIBUTORS .. Inside back cover
I.P.M. PROGRAMME & OTHER MEETINGS .... Back cover

NEWSLETTER No. 32 OCTOBER 1987

LIST OF OFFICERS

President	Dr. Tom Main
Vice Presidents	Professor Norman Morris Dr. James Carne
Chairman	Dr. Ruth Skrine (E) Castanea House Sham Castle Lane, Bath BA2 6JN
Secretary	Dr. Heather Montford (E) Cardinal House, The Green, Hampton Court, Surrey KT8 9BW
Treasurer	Dr. Jessie Yorston (E-O) 'Luibeg', Gardiners Lane Romsey, Hampshire SO5, 0BB
Scientific Director	Dr. Prue Tunnadine (E-O) Flat 7, Wimpole House 29 Wimpole Street, London W1M 7AD
Director of Training	Dr. Robina Thexton (E-O) 41 Hillcroft Crescent, Ealing, London W5 2SG
Senior Administrative Assistant to Director of Training	Dr. Audrey Jones (C-O) 1 Minsull Place, Park Road, Beckenham, Kent BR3 1QE
Programme Secretary (Elect)	Dr. Gillian Vanhegan (E) Westbourne, 9 Alverstone Road, London NW2 5JS
Programme Secretary	Dr. Jane Kilvington (E-O) 122 Marshalswick Lane, St. Albans, Hertfordshire AL1 4XD
Referral Secretary	Dr. Sheila Filshie (C-O) 2 Pembroke Drive, Mapperley Park Nottingham NG3 5BG
Panel Secretary	Dr. Margaret Gill (C-O) 10 Peters Wood Hill, Ware Hertfordshire SG12 9NR
Chairman, Research Advisory Committee	Dr. Katharine Draper (E) 29 High Street, Chipstead Sevenoaks, Kent TN13 2RW
Administrative Assistant to the Treasurer, also Membership & Subscription Secretary	Mr. Ronald Trowbridge 6 Dunsells Close, Ropley, Alresford Hampshire SO24 0DN Tel. No.: Ropley (096277) 2439
Newsletter Editor	Dr. Morag Bramley (E-O) Greenhills, Back Lane, Hathersage, Sheffield S30 1AR

Council consists of the President and 11 members (E), plus five co-opted members (C-O), one honorary permanent co-option, three ex-officio members (E-O) and one observer.

(C-O) Dr. Jenny Lisle, observer to NAFPD Council; (E) Dr. Anne Smith; (E) Dr. Susan Horsewood-Lee; (E) Dr. Gill Wakely; (E) Dr. Rosemarie Lincoln; (E) Dr. Merryl Roberts; (E) Dr. Ann Parker; Honorary permanent co-option, Mrs. Nancy Raphael; NAFPD observer on Council, Dr. Ann Morgan.

Mrs. Judith Green will be at 11 Chandos Street on Thursdays from 10.00 a.m. until 2.00 p.m.: Telephone 01-580 0631.

INSTITUTE OF PSYCHOSEXUAL MEDICINE

NEWSLETTER No. 32, OCTOBER 1987

EDITORIAL

Having struggled with this my first Newsletter I now realise how much we owe to Joan Coombs for steering it through the last three and a half years. Thank you Joan.

I would like each Newsletter to concentrate on one specific subject. This issue centres mainly on male problems. It is easy to think that impotent unemployed men will find difficulty recovering their potency before they are re-employed, but three articles here belie this assumption. A fourth article illustrates that although a man's job prospects recover, impotence remains till the underlying problems are tackled. In common with the other three articles mentioned, business failure or redundancy are precipitating factors rather than causes of impotence.

The difficulties of becoming an "expert" together with being faced with unaccustomed male problems are highlighted in two papers. Another article shows thoughtful management of a man's problem when the wife insisted on being present.

We were very fortunate to have Dr. Brendan MacCarthy to speak to us at our June scientific meeting. Some of that occasion is recorded here for those who were not able to attend. It is hoped that his ideas will act as a curtain-raiser for the next edition of the Newsletter.

He has opened for us the subject of child sex abuse and its aftermath, which throughout our working years has given us many difficult encounters with patients. It is likely that all the recent publicity will result in greater numbers of patients feeling freer to mention such problems.

Will you therefore think over any recent cases in which child sex abuse was mentioned and contribute a piece on your understanding of the doctor/patient relationship in one or more of these encounters?

This is a sensitive subject, so that proper disguise of names and social details will be appropriate.

The exchange of our experiences is very important and is a help and stimulus to many doctors who do not have the advantage of a seminar in their vicinity. The revealing of our own part of the doctor/patient relationship is always daunting, but by putting pen to paper our reward is that we are often stimulated to think more clearly of what exactly happened and to understand why it happened.

As this term begins, be on the outlook in seminars and in clinics for suitable cases to be reported for a wider group through the medium of the Newsletter. The last date for copy is 31st March 1988. Please follow the instructions to contributors on the back page when you write. I look forward to receiving your contributions.

Morag Bramley

Report of I.P.M. Scientific Meeting addressed by Brendan MacCarthy, 5th June 1987

INCEST: THE AFTERMATH

Dr. MacCarthy I will begin with a definition of psychic trauma. It is a trauma which abruptly overcomes the ego's capacity to provide a minimal sense of safety, resulting in overwhelming anxiety and producing an enduring change in the organisation of the psyche. I will not discuss the controversy over definition, Freud's original theory of childhood seduction or any generalisation on the effect of parental relationships, but give the observations I have made from my own clinical experience. This has been with over one hundred children, families and adults — with particular reference to eleven cases. These underwent long term analysis, four to five times a week.

Most of the cases were father/daughter incest. This is also found by others to be the commonest relationship presenting clinically, although not necessarily so in absolute terms. Brother/sister incest may be commoner as an occurrence, but not reported clinically. Other relationships may well be under-reported, particularly father/son.

The first encounter usually occurs much earlier than that stated, as processes of denial obliterate earlier memories. In the eleven cases under review the average age of onset was 4—6 years, not 8—9 years as stated; in three cases of the eleven it was before the age of four years.

Incest experience does not generate any special pathology of its own and the small child's developing personality may be a factor if there is a strong wish to please. This is often considered a desirable feaure in a child and may make her more at risk as her willingness to keep a secret is also related to the desire to please. In a survey of offenders, daughters with no sense of confidentiality had been avoided. Incest usually starts with a calculated act, pondered over for a long time previously.

Many victims present as anxious, with hysterical features, prone to depression and low self-esteem. Some are distrustful, fearful of criticism and even paranoid. There are problems with relationships; the majority do not enjoy intercourse and some are phobic about male and female sexuality. Disturbed dreams and nightmares are common. Some are withdrawn, anti-social with anorexia or obsessional features. Varying degrees of self-loathing and guilt are prominent, suggesting a deprivation of maternal protection which leaves a feeling of emptiness. Oral dependence may be expressed by an addiction to drugs or alcohol, and some even become suicidal.

There are major milestones, or hurdles, in the life of an incest victim and they include -

1. Making a stable relationship and the problem of the partner's attitude and whether to tell or not.
2. Getting pregnant — and this may be a fear even of an 8-year-old where there is no sexual penetration. There is also a fear of giving birth to a deformed child, or that the doctor or midwife will be able to know what has happened. There is fear of a female child becoming either a victim or a rival, and the age of incest onset may be determined by the mother's increasing anxiety as the child reaches that age. She may even have a breakdown at that point.
3. Father's death.
4. The menopause and the end of fertility.

The most damaged victims will not reach the first two of these hurdles. Some opt out and may even live like hermits. However it is possible for some to pass all of them and lead quite fulfilled lives.

In the simple situation of an approach by father to the sleeping girl of 4—6 years at night, first contact is always completely obscure to the victim at the point of investigation or disclosure — the patient does not remember. Adolescents may well remember in great detail, but the younger one never does, and questioning may be resented and felt as further abuse.

Vaginal penetration is rarely attempted before the age of nine or ten in inter-familial incest, but intercrural penetration and oral and manual stimulation of the child's genitals and perineum are common, and manual stimulation of the father's penis and fellatio may happen. The incestual affair may bestow a special status on the child as a 'favourite', but this will not dominate; the child tends to be confronted in a darkened room by a furtive, silent father, even disguised by towelling or by blindfolding, with heavy breathing, pounding heart and copious perspiration. The child may wrongly perceive ejaculation as her own incontinence. She may even think the father has had a fit or heart attack.

Children often feel parents have a right to touch and inspect them, and a caring father may well do so in helping his daughter to get out of bed and urinate at night. However the roles are reversed when the father is agitated, tumescent and orgiastic and he then become an abject, plaintive and guilty person in apparent need of 'care' by the child. The father becomes an infant and there is no mother present and the child feels desolate at father's 'disintegration' — often later re-lived in dreams of moonscapes or deserted railway stations with no people. Dr. McCarthy believes it is this rescue act that ensures the child's silence, as over 40% of children were neither threatened nor bribed. This also makes the incest victim very concerned later in life at the basic stability of the professional who is trying to help them. They are exacting and unforgiving patients who invoke deep hostility. Therapists need to be aware that their own compassion may well conceal a sado-masochistic wish to punish and deprive the 'over-indulged' child, evoking memories of their own unrequited oedipal longings and making these such difficult cases to treat.

Therapists often make the mistake of being sympathetic or of adversely criticising the father/offender and then being mistrusted by the patient as an unreliable, biased person who judges without having seen the person concerned.

There is always ambivalence about telling the story. She may feel empty at the loss of her secret which has been her interesting or powerful asset, but interpretations should be confined to the conflict she has of whether or not to tell and whether she will be believed.

Patients have described the morning after as a most painful rejection, as they had looked for some kind of acknowledgement to come to terms with what had happened and felt doubts about whether it had really happened at all, until the next time. This could well be a factor of the 'pseudo-promiscuity' that some of these victims experience. They have a string of short relationships ending acrimoniously and often when it has reached the stage where it would be reasonable for the partner to stay the night. The thought of marriage becomes unbearable because of the association with the morning reminder of the earlier painful experience. The whole of family life is distorted. There is a fear of family break-up and the monitoring of the father's behaviour — Is he strict, to reassure the family she isn't special? Is he kind, as a payment, or for what will happen tonight?

It is often helpful to interpret that the family break-up they so feared really happened on that first night and only the child knows it. There was a particularly distressing case of a girl of twenty-two who wanted help, having been abused from the age of four to eleven years. She was an achiever at school and her fear was that the police would find the obscene pictures her father had taken. At nine years old when police came to her school, she fainted. At 11 years her mother questioned her after she was found sleepwalking. When she told her what had happened the girl was beaten and called a liar and a prostitute and that she was possessed by the devil. When she mentioned the photographs, the mother found them hidden, had them burnt, left father and no more was ever said. The girl had found it easier to tell about the photographs than to face the discrediting of mother's insults, and even had fantasies about blinding herself in the chemistry laboratory. This girl did well in analysis.

These patient are not easy to treat and one must expect failures. Individual or group therapy may be invaluable and it can be very rewarding to see a victim grow and develop. As professionals we must free ourselves from our own incest taboos if we are to help these victims who, until fairly recently, had nowhere to go.

This talk was warmly applauded and followed by lively discussion and questioning from the floor.

Discussion

Dr. Tunnadine It is unusual for a patient to come complaining of incest, but it is common for the story to come out, and I wonder if it is easier if the doctor is 'a woman of a certain age' — like us — and although a few who come are deeply disturbed, some seem to get help from our approach. Perhaps we see a different population.

Dr. MacCarthy My present referrals are more deeply disturbed than previously and I do not know if incest is compatible with normal development. The only ones who have said to me that they found it in no way harmful were male homosexuals — none were female.

Several others recollected remarks made to them, such as 'enjoying the closeness', but disliking what he did and his unkindness in front of others, *or* a mother saying, 'You'd better go in to your father now'.

Dr. MacCarthy Open collusion is uncommon or subtle and if the child tells, the colluding mother goes straight to the police — but I know of a mother with mitral stenosis who told her eight-year-old she would have to sleep with her father, until she menstruated, when mother passed the duty on to the next daughter.

Dr. Pasmore The problem of differentiating between truth and fantasy was not expanded.

Dr. MacCarthy Often they say that they knew it was going to happen and it was almost a relief when it did, but I query this oedipal fantasy theory. When I have asked offenders, "When did you first *think* about an incestuous relationship with your daughter?", the response has been, "The day she was born" — and even at five months pregnant, thinking of girls' names and feeling sexually aroused. Perhaps the child picks up this dynamic.

Dr. Tunnadine It is important for an adolescent girl to have her emerging sexuality 'blessed' by father.

Dr. Hutchinson I had a non-consummated patient who avoided her stepfather by staying out of the house and 'freezing' and remains frozen with fear of the shock of what will happen if penetration ever occurs.

Dr. Tobert Are there any consistent personality traits in the father?

Dr. MacCarthy No, only the paedophile who could either be an aggressive authoritarian man or a very meek and timid creature. However there may be some features, such as a history of incest in the family, or experiencing it themselves, or severe deprivation such as death of mother at his birth. I remember a man with a desolate childhood, abandoned at two days, sexually assaulted at 12 and later imprisoned for five years. He had only ever asked children to take off their clothes, but somehow wanted to be isolated and punished.

Dr. Skrine Is it possible to help the mother's sexual relationship and so reduce the father's incestual wishes?

Dr. MacCarthy It does not follow that the parental sexual relationship is poor. Some men are fascinated by 'innocence' and 'purity' and have phobic dread of pubic hair as they fear penetration that cannot be clearly seen and the pubic hair obscures this. Moreover the child is non-judgmental and never sees him as a failure.

Dr. Main I am very interested in the morning-after phenomenon, the traumatic event and the child feeling lost and alone. Many little girls are frankly seductive towards their fathers, not sexually in an adult sense but tenderly, and it depends on his response as to whether there is trauma or abuse. He usually responds appropriately in a tender and loving way, but if the response is sadistic or an aggressive one of sexual passion then this is followed the next morning by the failure of her expectations of resuming a tender, loving relationship and hence her feeling of loss and despair.

Dr. MacCarthy I agree, and often these girls do not have the usual family fantasies such as, 'when I grow up I'll marry Daddy', and very few produce dreams — dreams are dangerous.

Dr. Backer Perhaps it can be enough just to share the problem. Only 8% of children who 'phone Childline give their name and there is an effort *not* to be traced. In clinics we often share grief and distress.

Dr. MacCarthy There is a similar response of Parents Anonymous. Offenders 'phoned in, but few come for an appointment. There can be a problem with confidentiality. One has to remember it is the child who is the patient, not the parent, and there is no obligation to report a father who is no longer living in the same house. In principle the child's accusations should be believed, but nowadays this may no longer be true and invites exploitation. The police often want to see records, but these are always refused and they do not usually insist.

Dr. Hutchinson No records are available without a subpoena.

Dr. Dewsbury A girl I have seen whose sexuality had been awakened and who realised she could say 'No', but still loved her father, found that her ambivalent feelings made it difficult to make another relationship.

Dr. Main The rage felt at mother can be overwhelming.

Dr. MacCarthy Yes, I agree and I recall one patient who compared me with her — as being a lazy so-and-so, just like Mother, just not noticing. I dislike generalisations, but the younger the child, the more severe is the damage.

Dr. Skrine Thank you, Dr. MacCarthy, for a very interesting and stimulating afternoon. It has helped to deepen our work and given us all a great deal to think about.

Audrey Jones
I.P.M. Member

TO LEAD — OR NOT TO LEAD? . . .

Report of the Leaders Weekend Workshop, 3-4th April 1987

The Workshop, held in Chandos Street, began with an argumentative business meeting. When I first attended basic seminars I assumed that my leader got her skills direct from on High. In fact, of course, she honed and polished her expertise in London-based Leaders Seminars. Such is the nature of this Institute that our leaders, who are sowing the seed corn of our future, travel to these seminars over long distances, in their own time and partly at their own expense. To ease this load a proposal for fewer seminars was made. The meeting then divided into two. For new leaders, this threat to an essential lifeline produced a sense of panic, whilst the more experienced were content to meet less often. A compromise was reached, but differing needs remain and will surely re-surface.

Our research committee battles on, attempting to demonstrate the effectiveness of our work in a scientific way. During the two years of a basic seminar, doctoring skills change, often dramatically. *We* all realise this, but how to demonstrate it scientifically to the satisfaction of others? The committee has devised a way of assessing the development of new perceptions and techniques, very impressive and essential — but the load of gathering the data falls on the seminar leaders! Those present blanched visibly, but the sound of gritting teeth was heard around the table, and this extra burden shouldered, if not joyously, then certainly steadfastly.

Two nurse seminar leaders spoke of the particular difficulties facing nurses interested in this work. Those of us who lecture to nurses can testify

as to their great enthusiasm. Many find financing seminars a problem, and worry about where the seminars are taking them. This surprised me, as I assumed that nurses entered seminars to enhance their skills and insights and enable them to do their ordinary work more effectively.

We broke for a delicious supper, provided by Wyeth, before knuckling down to the first of six work sessions.

I attended this weekend as a groupless observer, and I find reporting the real meat of the work session very difficult. I became so interested and involved in the sessions that note-taking was forgotten. Leader after leader presented a complex web. A case presented by a seminar member reflects not only the need of that doctor for help with a patient, but the doctor's worries about the pressure of the group and the demands of the work. Each group responds in an equally complex, individual and unique way. In the centre of the web sits the leader, struggling to understand the tug of each strand, trying to keep the group working in the here and now, balancing the needs of patient, presenting doctor and group. Or so it seemed to me.

I found listening to it all terrifying, exhilarating and rather confusing. Certainly it was very hard work for all concerned. Most of all, I was filled with admiration for the speed with which a group became a whole and began to work. I emerged tired, but with a greater respect for the skill of leaders, and a rather depressing sense of personal inadequacy. Funny, I seem to remember feeling exactly the same in basic seminars.

Thanks are due to the generous hospitality of Wyeth, without whose sustenance many of those present would have declined into an exhausted coma! Even more, thanks are due to Dr. Prudence Tunnadine for her tireless efforts in organising yearly an ambience where all leaders can benefit, learn and contribute.

Dr. Merryl Roberts
I.P.M. Member

"GETTING US SORTED OUT HAS HELPED ME STICK UP FOR MYSELF"

Mr. C. was a plump Scotsman of 48 with a round balding head and a friendly manner. He always referred to himself in the plural, which initially somewhat confused me. He came for a special long appointment which "us telephoned to make" following his doctor's suggestion that he should be referred to me for help. The referral letter said that he had recently complained of erectile difficulties when consulting his G.P. for routine matters connected with diabetes of a year's duration.

I asked him to tell me about the problem in his own words. He talked at first hesitantly and then confidingly about "problems with erections" and the need "to get us sorted out", because this was yet another blow in two years that had been "difficult all round". He had worked for a long time, often abroad, on oil rigs which gave him the means to have an affluent life-style. However he had foreseen problems in the oil industry and settled in a semi-tropical island; changed to working for himself, married "a real

beauty" and for many years lived a prosperous and palm-fringed life-style which sounded worlds away from the windy rainswept Clinic building in which we were talking.

He spoke without swank, of his ability to buy gold watches for his friends or jewels for his wife from visiting traders ("not just showy things, something special") and it was obvious that he treated her like a queen. Sex was fine and they had a son who grew up "to help us in the business", which was something to do with importing and leasing cars. They later had a daughter. However, something went wrong with tax and insurance payments in connection with the cars and it was not long before he found himself with debts he could not meet and legal battles pending. He had returned to England with his wife and 11-year-old daughter, rented a house near his elderly mother and by now was in fact receiving Supplementary Benefit.

He told all this in a factual way as if just to explain the "difficult last two years" and I did not feel that he was trying to elicit sympathy. He dismissed the situation by saying that he was sure "us will get that sorted out and get back, no question", but now his wife, who was five years older than he was, had not only had to adapt to the changed life, but the poor soul was having a terrible time with the menopause and migraine headaches. These always came on badly if she was aroused sexually but got no orgasm. He failed to give her a proper climax because he sometimes lost his erection: he, who had always been proud of his sexual prowess.

His 80-year-old mother, near whom they were now living, always expected him to be able to sort out her problems, medical and domestic. She was still a "formidable Salvationist" and while "becoming more and more dependent on us, tells us off properly if she has a mind to".

The diabetes was brushed aside ("we've lost the weight the doctor said we should, we're fine and the tests are always blue") and I remarked that he seemed to be trying so hard to please everyone else that he wasn't allowing himself to admit to his own feelings at all. Gradually he began to acknowledge how things "have put us down". His impotence, something he never dreamt would happen to him, coupled with everything else, "made us feel less of a man". Finally a belittling comment by his wife had made him say, "now look, Sweetie, us will ask the doctor for a bit of help".

There was a feeling of sadness which we both acknowledged and a thoughtful silence as if grieving for glories past. I noted that it was his need to please his wife which had finally spurred him to seek help in spite of himself and we looked at this. He had taken her to several specialists about the headaches but no one found any cause or seemed able to help. The headaches made her lose her temper so easily that it was like an erupting volcano and "we have to choose just the right moment ever to say anything these days", but "it was no wonder after all she had gone through". It was no wonder, either, that the infirmities and problems of old age made Mother so irritable and bossy. I commented that he must feel resentful at having to tread so warily round these two powerful ladies and he said, "Oh doctor, you've no idea . . ." — then a long pause and, "but actually I think you *have* — and here's us actually admitting how fed-up us gets skirting round them both. Us can see the reasons why, but it does make life difficult".

He had expected to find that his problem was psychological — indeed, his G.P. had hinted at it — and as he could get morning erections "it seemed that the circuit worked", but he hadn't been able to work out "why it sometimes wouldn't". He acknowledged that his anger could not be expressed in words — it wouldn't be fair on his wife after what she had been through and anyway the volcano would blow up and he preferred to keep the peace. He chuckled at my suggestion of his penis on strike, but said, "it's down but not out — it's not running away, us has always been a fighter". We discussed the potent weapon of an impotent penis and, as it was late in the evening and I felt that plenty of work had been done for one session, I got up to show him out of the building. To my surprise he went to the waiting room to collect his magnificent buxom African wife and, giving her a hand up from her chair, said, "look, Sweetie, this is something between the both of us and us is going to get it sorted out". As he towed her through the door, I was left wondering whether my confusion over which "us" was him, was just because I was tired!

He came again after three weeks delighted to report a big improvement. Occasionally he ejaculated too soon, but "us is usually getting it right." He had done a lot of thinking since his last visit and he and his wife had done more frank talking than since leaving the island, though he had been careful to choose his moments. She was always strict with their daughter, now thirteen — "it's her culture to be, you know" — and to keep the peace he usually left it to her, though this often caused problems. He felt very badly about not always being able to meet "the bairn's requests" for money for extras and school trips, but mostly the problems were about her mother's restrictions on allowing her out. He had always been close to his daughter and she would still turn to him for a cuddle, especially when upset.

Since his last consultation his mother had seen him with his daughter on his knee and had been shocked and told him off in front of the girl, "as if us was doing something naughty". But us said, "Now look, Mother, I'll help you with your finances, and the bungalow, and getting your cataract appointment altered, and you can say as many Hallelujahs as you like, but how I treat my own child in my own house is my affair and you don't interfere!" His wife overheard and "was proud of us" and things were hunky-dory in bed that night and no headaches!

We discussed whether he wanted another appointment and I said that he didn't have to come to please me as well, and he grinned and said, "I reckon I've got us sorted out now us understands and I can stick up for myself" (the first time he had referred to himself as "I"). "Well, that's what you wanted, wasn't it?" I said. He instantly saw the double meaning, smiled and said, "Yes, that's it, doctor. Thank you, that's it". I wonder?

Dr. Barbara Devereux
I.P.M. Member

A MAN WITH A PROBLEM

His wife telephoned in tears asking for an appointment. I suggested she wanted to consult me by herself but she was sure her husband wanted to come with her.

When they arrived Mrs. H. was dressed in crimson velvet; she was looking distraught. Mr. H. was a well-groomed heavy man of 55. I thought he looked professional and could have been a surgeon. I remember saying to myself that I would not expect him to find sharing ideas easy.

I was wrong on both counts. Mr. H. talked readily and long. He said that each night for 35 years he had slept with his wife and each night for 35 years they had had sex. It had long been an occasion of little excitement for his wife but it had always been a pleasure for him. He then embarked on a detailed description of his recent sexual experiences with another woman.

As he rehearsed their every activity his wife began to cry. He took no notice. A comment of mine about his discoveries and his infatuation renewed his eagerness to talk and we heard more. He said his wife on her return from nursing their daughter abroad had screamed and shouted. She started to shout now. I was quiet and helpless in the middle. No hint of remorse or apology did Mr. H. show. He went on talking.

By this time my feelings about his present behaviour had progressed from interest to patient indulgence. They finally turned to disgust. I remarked aloud that I could understand that he had become infatuated; I could accept that he had never known anything like it before; what I couldn't understand was why he repeatedly said things which distressed his wife so much and how it seemed he had continued to do this for several weeks.

Mrs. H. then said she had done everything she could to win him back. Indeed she had made many changes in her attitudes to sex and had learnt of many new ways she could please her husband. Mr. H. confirmed this and said their daily sessions were much longer and his wife responded very differently and he was delighted. Still no tenderness. Still no kindness. No acknowledgement of her need for him or his for her. They had an argument instead about whether Mrs. H. was reasonable in cancelling all her engagements so that she could be at home to monitor his activities.

I do not usually flinch at the subject of adultery but I hated this man for injuring and distressing his wife. I hated him for all the details of his love-making with which he seemed to taunt her.

Then suddenly and to my surprise he said: "I know I've been a heel". We exchanged glances solemnly and I acknowledged what he had said with an affirmative nod. This man had at last said what he had found it so difficult to say.

Mrs. H. had originally asked to see me and had not had much chance to talk. She was still stretching her hanky out and dabbing her eyes. I asked if she would like to come on her own. She said she didn't know, she would see. Then gathering her things she said, "Send me an account and I'll send you a cheque". A bit dismissive. But Mr. H. got his cheque book out and with something of a flourish wrote me my fee.

I was not sure what had happened. My feeling now is that my intense loathing for this man was something to do with a part of him which could not acknowledge the loathing he had for himself in acting so disloyally. He gave me a clue when he so readily rewarded me and I thought it was as if he was saying: "Thank you for *not* saying what I found it so difficult to say, but giving me time to say it for myself".

Was I right in thinking that I had felt his feelings for him? I also wondered whether his wife's harsh criticism of his behaviour and her need to watch him in case he strayed again, as well as being her own angry reaction to unfaithfulness, was not also to some extent a reflection of his need to have his perfidy acknowledged and his behaviour restrained; neither of which he could easily do for himself.

Dr. Jane Kilvington
I.P.M. Member

REDUNDANT

At one stage I seemed to be seeing many men referred because of impotence, in whom the symptoms had been precipitated by redundancy. Rather than being the sole cause, redundancy appeared to be 'the last straw' which stopped them coping with other life stresses. Resolving the distress was thus not dependent on a new job.

Mr. A., a dejected looking man of 45, came complaining of failure to get an erection over the previous 18 months since losing his job. He was no longer having morning erections. At his wife's insistence they had recently moved from an area of moderate unemployment to an area of high unemployment, which hadn't helped him, but his wife now works. He resents her independence. The relationship started when both partners had been deserted by their respective wife and husband, and both had been vulnerable. They had since married.

At a second visit Mrs. A. came too, though not invited. She came to insist that I cure her husband by tonight because she was fed up with the situation and felt rejected. Mr. A. sat fidgeting, and she told him to go to the toilet. He obeyed. I commented on the incident and she angrily told me that she always had to tell her husband what to do, as he had no initiative of his own. He never did anything properly.

At a further meeting with Mr. A., I again discussed the incident and the lack of emotion on his part. How did he feel about being treated like a child? He calmly told me that it made him angry, but he was afraid to show it. His father had been a very violent man, particularly against his mother. Mr. A. hated his father and didn't want to be like him; also he was afraid of showing anger because he'd seriously injured a friend as a teenager in a fight, and had since learned to walk away from trouble. Mr. A. was happiest looking after his children and a younger, disabled brother.

Before Mr. A.'s last appointment I received a vitriolic letter from his wife. I was wasting my time. He was no good, and she was considering divorce.

He arrived and sat with tears of despair streaming down his face. I felt totally inadequate too. He had tossed a coin to decide whether or not to see me or to continue walking away. During the last week he had woken with an erection but had been too afraid of his wife's anger at being woken up to make use of it.

He didn't keep a further appointment.

Mr. A. had coped sexually in this relationship to start with in a caring role, comforting a deserted wife. As she recovered from this setback and regained her independence he also lost his job and supportive role. He could no longer cope with her increasing sexual demands or express his anger. The only solution he could apply was his learned one of walking away.

Mr. B., a pleasant-looking man of 48, came in looking very apprehensive. He had been experiencing increasing difficulty in getting and maintaining an erection over the past four years. I found myself reassuring him that this was a common temporary problem. Why had it happened now? He relaxed and sat back. Problems had started when he had been made redundant from a skilled job, with no hope of finding similar work elsewhere. Re-training had produced two temporary jobs in the area, but he kept being rejected as too old for a permanent job.

Physical examination allowed him to express his fears about being too old for sex. Not only employers but his body also was letting him down. When dressed he expressed frustration at being tied to his wife's home town. She wouldn't live anywhere else. Was she letting him down as well? He defended her. They had a very good marriage and he hadn't minded staying put while he'd had a job. In the past he had wanted to emigrate, and would really like to move to find work now, but hadn't discussed it with his wife.

He was reluctant to express his anger at this situation, although I had felt it strongly. He eventually agreed that at the beginning of their marriage he had been angry about not moving, but thought he'd got over that now. I suggested that his present difficulties with work had brought the anger back, and he left to think further.

In a second interview, Mr. B. looked no more confident, and admitted that he had not discussed his desire to move with his wife. Intercourse was no better. I asked again about the jobs he'd been looking for, and the frustration of not finding work re-surfaced and communicated itself to me. I commented that his anger and frustration were near the surface and he accepted this, but still queried the necessity of discussing moving with his wife. He knew she didn't want to move, so why upset her by discussing it? He was sceptical about this lack of communication being related to his difficulties in intercourse. He then told me about a job which interested him in another part of the country, near a daughter. Perhaps his wife would be willing to move there. We ended the interview at this point.

The third time I saw Mr. B. he came in looking very bright and cheerful. Intercourse had become more frequent and good again. For the first time in their marriage his wife had found herself a job, using domestic skills. How did that make him feel? He was proud of her achievement and felt that she

was contributing towards solving their problems. He was no longer under such pressure to find permanent work, but had more confidence in doing so. There was really no point in moving and taking his wife away from her job. I felt that this patient had learned to stand up to the doctor!

Throughout these interviews Mr. B. seemed very protective towards his wife. There was a lot of suppressed anger about the immobility she imposed, but whenever I suggested any criticism of her attitude, Mr. B. rushed to her defence. Mrs. B.'s job seemed to give her husband the excuse he needed not to pursue the conflict. It also provided ammunition to tell the doctor she was wrong.

Dr. Margaret Wheatley
I.P.M. Member

IMPOTENCE: IS REDUNDANCY THE CAUSE?

Dr. Wheatley's remarks before the preceding cases reminded me of another patient who did not need re-employment to regain his potency. A rather gentle white-haired good-looking man of 44 years was sent to me by his G.P. because of two years' impotence. He had been to hospital for a full medical check-up but no possible cause for his impotence had been found.

"Is there something you can give me for this complaint: some tablets, perhaps?" he asked. I suggested that understanding the problem might be useful, before considering drugs. How did the problem start?

He described in an almost trembling voice how two years ago computers had made him redundant, and so he was moved to a department where heavy labouring work was required. The young men who worked with him laughed unkindly at his puny physical efforts. He sought some help with this enforced change of work, from his union. His manager was incensed by this and held a chair over him threatening to kill him. The young white men said that they would throw him out of the window and jeered at him with insulting names because he was coloured.

He became so upset that he could neither eat nor sleep and his family begged him to leave. He eventually did so while feeling really humiliated. He looked so upset as he related this and almost wept. I shared the painful moments with him and then suggested that he had almost lost respect for himself and his abilities and the humiliation was almost too hard to face. He said that he felt this was true.

In a calmer voice he then told me that some years ago he had been turned out of his home in Uganda with no money or possessions and had to spend two years in a refugee camp. After gaining a job and establishing himself and his wife and five children, he had the further setback of becoming redundant because of a miners' strike. His recent job he had done efficiently for six years until the computers took over. He was not begging for pity but somehow bolstering himself up in order to feel that he was not altogether incapable. I commented that a person who could rise above such difficulties twice could surely do it a third time. He thanked me politely and left, leaving me feeling that he had a strong need to keep people thinking well of him.

This reminded me that he had tried to keep his wife happy by installing single beds so that she would not be frustrated sleeping with him and never having intercourse.

He returned in a month and said that things were no different. My heart sank and I could feel his depression. He had tried and tried for jobs, but they always wanted qualifications or experience or a younger man. He was sitting at home doing nothing now.

He went over again in more detail the awful humiliations he had suffered before he had left his last job and expressed more anger than previously. I suggested that as he seemed to be able to go over these indignities with a little less pain now, perhaps he was ready to get up and do something for himself instead of sitting at home. Was he ready to put the past behind him now as he had managed to do on two other occasions?

He looked at me and said, "Are there no tablets you can give me, doctor?" "Tablets won't take away the pain of humiliation", I said. When another appointment was suggested he said, "What is the use of it?" I suggested that he might have done some thinking for himself by then. He said he would make an appointment and cancel it if there was no improvement. I was pleased that he was making a positive suggestion of his own, and had been able to show some aggression.

He came two months later. He was smiling broadly and said that he was better. His potency had returned and his wife was pleased. Her feelings seemed to be more important than his own success. "What about *your* feelings?" He said he had started doing gardening and odd jobs and had set a course of reading for himself. He was really enjoying doing things again!

He had thought a great deal about the cruel treatment he had received at work and had decided to put it behind him now. He was applying for jobs, had no success yet, but he felt that he was more confident in the interviews now.

As he left he shook my hand warmly and thanked me profusely about three times. I thought to myself, "I see you have got to keep me thinking well of you also!"

When the unfortunate results of his redundancy from the clerical work had been faced, this man could regain his potency without getting another job, but I feel sure he will get one soon with his more positive attitude.

Dr. Morag Bramley
Editor

THE MAN WHO COULDN'T KILL A MOUSE

Peter B., a large balding man, aged 57, was referred by his general practitioner with a four-year problem of impotence.

In spite of his casual dress of jeans and waisted jacket, he looked very formal, sitting upright, seeming to overfill his chair, and he treated the doctor with jocular friendliness and sometimes a phoney deference. Once or twice he said, "Well, I don't know what else to tell you, Ma'am". He ran a

successful building firm in which his wife was a co-director; he provided the technical expertise, but she managed the books. He said she was much better at "that side of things" than he was. They made a good team and complemented each other. One of the sons worked in the business but the other one was too much like him.

Four years ago he had been sued by a customer for using sub-standard materials in a house which he was building and, although the real fault lay with the manufacturers, the court case went against him and he had to pay out a large sum of money in damages. He was not insured for this. The legal proceedings became very bitter and he only managed to repay his debts by the sale of some family property. Although this was accomplished and the business remained solvent, Peter became quite depressed and blamed himself for his incompetence. The doctor pointed out to him how impotent he felt at that time, adding that impotence was not just a problem with the genitals. His wife was reassuring and supportive, but he accepted the responsibility for an error of judgment which led to their financial difficulties and he felt diminished in her eyes.

A consultant physician diagnosed that the impotence at that time was due to his depression and thought that as the business recovered he would get better, but this had not been the case although the business was thriving once more. Clearly this was not the whole aetiology of the sexual problem.

It was very difficult for the doctor to find a chink in the defences about his relationship with his wife. Their sex life had been active and enjoyable and his sexual appetite was vigorous and "she would never refuse him". He was ready for sex at any time. They had an ideal marriage and always slept curled up together in bed, and were rarely apart during the day. He did volunteer to the doctor that he became very angry if any man paid attention to his wife and had even hit a chap on one occasion. He said that he knew his wife was not really flirtatious but he became very jealous and had a short fuse where she was concerned.

This led on to a discussion about the importance of him coming first in his wife's eyes and his uncertainty about this. The puzzle was to understand the disturbance in the relationship resulting from the court case which was perpetuating the impotence.

After two visits Peter said that his early morning erections were becoming more powerful and more frequent although they only occurred when his wife was asleep. He was feeling more optimistic for change. The doctor, still trying to find a way round the defences, started to ask about any disagreements which they might have had. He said, "We never quarrel, but my wife did leave me once for two hours when I was unable to kill a mouse which got loose in the house!" The doctor interpreted that perhaps he felt that she thought he was not man enough for the job. Peter laughed and agreed and then went on to say how important it was for him that his wife thought well of him. The doctor was then able to point out how difficult it was for him to tolerate the failure of the partnership when the business was in trouble and to feel that he had let her down. The usual and acceptable balance of power was in jeopardy. He was developing some insight into the characteristics of the marriage relationship and this was made even more clear by the fourth visit, when he said that his erections had diminished again

recently after a time when he felt his wife was no longer interested in him. They talked about his feelings of anger and rejection and things had been happier again. He could now see that his sexual potency was dependent on the atmosphere between them.

On the next visit he brought his wife with him. She was a slim attractive woman, looking young for her 50 years and articulate and chatty. The doctor focussed on the aspects of the relationship which she had been able to observe in the 'here and now': for instance, it had been noticeable that the wife made the phone calls for the husband and arranged the time for his appointments, and the symbolism of this was discussed in the joint encounter with the couple. This led on to a wider discussion about the difficulties in the marriage and the effect of the financial problems. It was interesting that when the interview was drawing to an end the wife said, "Come on, Peter, I think it's time we went now: the doctor must be busy". Then she laughed and said, "Well, there I go again — I am a bit bossy, aren't I!" They departed together to go off on a holiday abroad. A phone call from Peter himself three weeks later told the doctor that not only had they had a very good holiday with good weather, but that the sex had been very much better and he didn't think that he needed to attend any more. He added, "Thank you very much indeed". It seems that the two of them have developed enough insight into their own marriage relationship to allow better communication and for the husband to feel more potent once again.

Dr. Rosemarie Lincoln
I.P.M. Member

TWO TERRIFIED PEOPLE

Mr. O. will always stick in my mind, as I have learned a great deal from this case. First, from the referral, which affected my feelings in the first interview, and secondly, because I have rarely treated a male patient with a psychosexual problem, this caused me initial apprehension.

Mr. O. was a 60-year-old man, referred to me by a G.P. who is highly regarded in our town: he organises the Vocational Training Scheme. It was an urgent referral that came to me secondhand, because the 'specialist' in our district was fully booked for the next three months. Please would I see him instead? I approached the first consultation with anxiety because (a) it was my first referral from a G.P. — and not just an ordinary G.P.! I felt that my reputation was at stake; and (b) I was now marked out as an 'expert', which put me under great obligation to make this man better; also (c) here was a 60-year-old 'man', with one year's history of impotence. I imagined treating a man would be different from treating a woman.

I was aware of all these feelings, particularly anxiety, as I went into the first interview. I did not look at them, or understand them, at this stage. I have since learned that understanding first interview interactions is always important.

The referral letter was brief and to the point. This man has a 12-month history of impotence, no lack of desire, but achieving only occasional, partial erections. He is hypertensive and on nifedipine. Please can you help?

I wondered if the anti-hypertensive treatment was causing or increasing his impotence.

Mr. O. presented as an unremarkable looking 60-year-old. He was of average height with grey hair and tidily dressed in a light-coloured jersey and sports jacket. He looked as apprehensive as I felt. He is an ex-miner, and he told me of his problem in a halting way and with some discomfort. I remarked on his discomfort and he then relaxed. He took voluntary redundancy from the pit four and a half years ago — by choice. It was an easy and happy decision to take, he told me (as is common with many miners after years down the pit). He and his wife took a holiday in Majorca immediately afterwards which was "great". On their return home, his wife proceeded to have a "full-blown nervous breakdown", as he put it. She was eventually admitted to hospital and he visited her daily. She was discharged "too early", and he coped with her for a long time at home, doing everything for her. Her behaviour was odd and child-like. Gradually she improved and over the last 12 months had become almost completely well again. She wants him to make love to her. He tries, but it doesn't work, and now he is afraid of letting her down.

My feelings at this stage were of great sympathy, which I showed to this man, who appeared to have been let down by his wife, just when life promised to be good. He would not admit to any feelings of anger or frustration with his wife. He appeared to be very loyal and protective towards her. He made me feel that I should not pry any more into this breakdown and the reasons for it. I was afraid of hurting him. Perhaps this reflected his feelings towards his wife. He feels her to be child-like and vulnerable.

The genital examination was very matter-of-fact. I realised afterwards that I had deliberately examined him as quickly and clinically as possible. I felt inhibited about asking him about feelings during the genital examination, which I would have done perfectly naturally and comfortably had he been female. During this hasty examination he showed no feelings at all. Having established his anatomical normality, he said, "I suppose I can't expect much at my age. It's bound to happen, isn't it?" His highly regarded G.P. had suggested that this is "what to expect when you get older". What were his feelings about that? "I don't know". He was negative and not at all forceful. Where were the feelings?

I was beginning to understand that here was just another psychosexual problem, and that the sex of the patient was irrelevant. He had described these unhappy four years in a very controlled way. He showed no pain or anger. I suggested that he had had to be in control of everything during his wife's illness. His wife had lost control of her feelings when she became ill; it would be dangerous if he also lost control. Perhaps learning to make love again would mean loss of control without fear. It was hard work getting any information from him. He was afraid of letting his wife down during love-making, but he had not let her down throughout all her illness. He had supported her through thick and thin. Could he not see that?

After that interview I felt pessimistic. He seemed inarticulate and had such poor self-esteem. There were two further interviews in the next six weeks. I had had time to reflect on my initial apprehension and had realised

with relief that whether males or females present with sexual problems, they all require the same attention, thought and understanding.

There had been a slight improvement after the first interview, with full intercourse achieved once. Two weeks later, Mr. O. told me things were as bad as ever, and I felt very let down. This was clearly coming from him, and then for the first time we began to talk about feelings, with feeling. I felt that his lack of confidence was a barrier, and it was beginning to make me feel impatient. His wife must feel the same frustration. Being gentle and sympathetic was not helping him at all. He had to let his feelings come out, and be more aggressive. This made him talk more freely, until we finished this encounter in a more optimistic mood.

I was unprepared for the dramatic change of the fourth encounter. Three months after the initial consultation, it took me completely by surprise. Here was a totally different person. Mr. O. had abandoned his pale yellow V-neck for a dark, ribbed, thick jersey. He looked younger, slightly 'butch' (which took me aback!) and he was quite cocky! He was achieving full intercourse regularly with his wife, and was feeling very happy. It was difficult to believe that this was the same Mr. O. His confidence had returned.

We reflected together on why things had changed so dramatically, as it seemed important for us both to understand why he was better. He was showing me feelings at last. This time, he was in charge of the interview. I was the one who felt insignificant and unimportant. He smiled at this.

I wrote my final discharge letter happily to the G.P. — and I have since had a further referral from him! Perhaps I did not let the side down after all. If I had let my initial apprehensive feelings overwhelm me without examining them, I could have ended up as impotent as Mr. O.

Dr. Rosemary Bradbury
I.P.M. Member

THE EXPERT: a cautionary tale

Three members of the Islington Advanced Seminar had recently taken on clinical appointments in psychosexual medicine. Each felt that she or he had under-performed in early cases referred to them at their clinics, and the group acknowledged this when cases were presented in the seminar. One such case is presented by each of the three doctors, and discussion of the common problem of under-performance follows.

Jane and Steve were my first referrals at a psychosexual session in a Community Family Planning Clinic. This had previously been run by an experienced and well respected Counsellor. Since her retirement, no referrals had been made until I was appointed to take her place. I felt she was a hard act to follow.

Jane had presented herself to another Family Planning Clinic in the area, complaining that her boyfriend was not able to ejaculate during intercourse,

and she wanted to become pregnant. The clinic doctor sent her on to me with a referral letter: we had circulated letters advertising the existence of the new psychosexual session and she was the first to respond.

When Jane and Steve first walked in I was so wrapped up in my own feelings of newness and uncertainty that I noticed little about them. Steve had come with Jane, as it was difficult for her to come on the bus. They agreed on very little, but seemed united in their hostility towards me. Steve did not think non-ejaculation was a problem, other than that it prevented Jane from becoming pregnant. Jane wanted a baby and A.I.H. was as good a way as any. The fact that they had only been together for three months, were not married, and seemed ill-suited as a couple was striking; and this added a new anxiety: I must on no account let them see how unsuitable I saw them as prospective parents. Jane successfully threatened me with her tears: "The other doctor told me I didn't want a baby because I wasn't married. . ." she sobbed. I hastened to reassure her. Steve sat with his arms folded, refusing to contribute anything. I cajoled them into returning the following week with the inducement that I would find out more about A.I.H. How could I let my first referrals leave after only one session?

At the second session I was in slightly better shape; largely thanks to having presented them to the Seminar during the intervening week. I am still not sure that it was anything but cowardly to separate them, but this I did. I saw Steve first at his suggestion. He was much more forthcoming on his own, but in retrospect, I think perhaps he was simply trying to make me like him better than Jane (in which case, he definitely succeeded). I tried to set the issue of A.I.H. to one side. I told him that since he had ejacuated during intercourse in the past, there was a good chance that he would do so again. "But what if I can't?" he countered every time. At the end of half an hour, he was still unable to commit himself in any way. He said he did see he had a problem, but the way it was dealt with was "up to Jane".

Jane appeared in an ill-concealed fury which reduced me to a dithering muddle. I feel sorry for her now and wish I could have listened more sympathetically to the underlying distress. I was able to learn something about her. She had two younger sisters who had both recently had babies. She was bored in her work and had little fun in her private life. She had few friends and felt unable to trust those she had. She was "sometimes orgasmic", but reluctant to discuss this. Life was dull for her and she belligerently tried to demand her share of pleasure. The subsequent disappointment she always experienced left her sullen and resentful. I felt her defiant challenge for me to help her, but could not respond. At the end of the session she said she did not want to come back, nor would she submit herself to any further questioning at an infertility clinic. The couple left and I have heard no more from them.

Writing this, I find it hard to believe I could have mismanaged a case quite so badly. For me it is just put down to experience. Reassurance of Jane and Steve without understanding their problems and failure to bring the anger of both into the open for discussion resulted in this couple sadly missing an opportunity to learn about themselves.

C.A.

Susan is a 31-year-old married secretary who had presented to her G.P. on several occasions with malaise and exhaustion and sometimes admitting to marital problems. She eventually complained of deep dyspareunia and was referred to me, after a physical abnormality had been excluded.

She was a neat, quiet, pleasant Jewish woman, who talked easily about her background. Her current marriage is her second — her first ended prematurely by her husband Peter's sudden death from acute leukaemia. He ended his days in a plastic bubble, where even touching him might have killed him, so neither of them could gain or give physical comfort when they most needed it.

Susan's second marriage is to Peter's first cousin, Mark, who is four years younger than her. She described her horror when he touched her, especially her lower abdomen and genitalia and how she, quite involuntarily, pushed his hands away. This had led to explosive arguments, and some violence.

I decided to examine her and during the vaginal examination I said, "This is an area of your body which doesn't give you much pleasure, isn't it?"; and then rather a long shot: "Does it still belong to Peter?" This remark was met by a torrent of tears and anguish. She literally screamed with the pain and unresolved grief of it all: her anger with Peter for having left her; her horror at all the drips, tubes and trappings surrounding his death; her anger at Mark's refusal to discuss any of her feelings about her first marriage. This was the first time she had cried or exposed her deeper feelings since Peter's death, and we silently shared the pain for a few minutes, whilst I sat on the couch. It took me also a long time to recover from the emotional upheaval of this consultation — I felt exhausted.

Our second discussion was short, snatched at a time when Mark would not realise that she was with me, as he had insisted that she did not discuss her feelings with outsiders. Susan was absolutely distraught, quite out of control. I wondered what I had started and whether she should not be in a more formal psychotherapeutic relationship.

I took this case to the Seminar, who recognised that the doctor was wilting. I expressed my fear that Susan would break down and that I would not be able to handle it. They urged me to stay with it: "You can't leave her at a time like this", one said.

At our next meeting, I realised that she was right. Susan had worked through masses of her past — her isolation from friends in childhood, because of frequent moves; her embarrassment about a squint; and the blow of having been diagnosed as epileptic. She also described a traditional Jewish ceremony which she had had to take part in, in order to re-marry, even though she was a widow. In the presence of senior male members of the synagogue, her brother-in-law offered her his home and she had to refuse him emphatically. She felt utterly degraded by this.

In immersing herself in these memories and in trying to rationalise her feelings about them, she had, naturally, become withdrawn from current events, to the extreme irritation of Mark. Things between them had reached a crisis.

Again, I took the case to the Seminar, with some wish to refer her on. "You're always trying to get rid of this woman", I was told. This time my anxiety was that the marriage would break up; but once again I was urged to

carry on working with Susan.

In our final session, Susan looked much more relaxed and reported more communication at home, on all levels. She had actually asked Mark to make love to her — he said he didn't know what had come over her, but was much relieved and willing to talk. We agreed that it was too early to be over-optimistic, but that this fragile reunion could be built upon.

I saw Susan recently. She still, sometimes, has to stop herself from pulling Mark's hands away, but it has become a joke between them. She has been relieved to admit to Mark that she has been seeing me, and has visited Peter's grave for the first time since his death. "I have to lay that ghost for ever", she said.

S.R.

Mrs. X. is 39. She is tall and slim and dresses well. She speaks without an accent. She appears self-confident. She was the first person referred to me in a new psychosexual clinic, in a new District General Hospital. To add to my anxiety, Mrs. X. had been referred by the gynaecologist who was sponsoring my Clinical Assistantship. He was known to me as "sympathetic to the Institute" and had attended seminars. He had already done some counselling with Mrs. X.

I determined not to read the referral letter until after the first consultation, so as not to be influenced by anyone but Mrs. X. She told me that she had, almost, lost interest in sex over the past three or four years, allowing intercourse only about every six months, when she might enjoy it twice or three times on consecutive days.

She had met her present husband about six years ago. They became business partners in the very successful employment agency that she had started on her own, after the break-up of her first marriage. She had two young teenage boys from the first marriage who lived with her. There had been a miscarriage in the present marriage and following this she had decided to be sterilised (about a year ago). At one stage she had had abnormal cervical smears and had been under the referring consultant's care for all these problems. In retrospect, I failed to help her see that she treated her gynaecological problems in a detached and practical way. This was also the manner with which she dealt with the vaginal examination.

I resorted to asking questions, and realised that I had opened a terrifying Pandora's box. Her father had been a merchant seaman (a remote, authoritarian and little respected man, when at home). Mrs. X. had argued with him and defied him from an early age. Her mother, of whom she was very fond, had died in violent circumstances: murdered. I tried to share the horror of this with Mrs. X., but she was unable to let me, preferring to tell me about her anger at her father's re-marriage very soon after his wife's murder, and her shock that the new wife wore Mother's jewellery. She sees her father as little as possible but feels the need for her boys to keep in touch with their only remaining grandparent.

Her first marriage had broken up before her mother's death; separation had been a relief as the marriage had been emotionally violent. However,

her sex life had been satisfactory.

She loves her present husband very much, but feels guilty, yet unable to give in to his sexual advances except very occasionally. She would not agree with me that she "wore the trousers" both at work and at home (she wore slacks to all her interviews with me), but regarded both environments as equal partnerships with her husband. She wanted me to meet her husband. I did not wish to meet him, but out of courtesy agreed to see him for "ten minutes". In fact, he came with her to our second meeting, and I found myself ignoring him. I failed to interpret this.

I tried to make her talk about the violence in her life, but she felt it had little to do with her loss of libido. She controlled me (as I suspect she does her husband), but I failed to make use of this. I had focussed on the horror I felt (but could not persuade her that *she* felt) over her mother's murder and father's callousness. I was so convinced that it was this part of her life that was the main cause of her complaint that I offered to arrange for her to see a consultant psychotherapist. She declined the offer.

When I reported this case at the Seminar, my colleagues pointed out that I had needed to fight with Mrs. X., as she had with her father and first husband. To have followed this line, I am sure, would have been much more constructive, as I can now understand that her present husband will not fight. When I talked about "wearing the trousers", she managed to control me, and won. I had tried to control her, as her father had, and I needed to fight her; I would not read the referral letter; did not want to see her husband; tried to make her see a psychotherapist.

I failed Mrs. X., her husband, my gynaecologist-sponsor; and my seminar colleagues felt I could have done better. In retrospect, I know that I could. I had not proved very 'expert'.

K.S.

Discussion

The common ground of the three cases presented revolved around the doctors' very early experiences as 'experts' in psychosexual medicine. None managed to justify the handle 'expert' to their own satisfaction, and the seminar group as a whole left each doctor in no doubt that she (he) could (knowing of the doctor's previous work) have done better.

Two of the doctors were starting entirely new psychosexual clinics. All three found themselves in unfamiliar surroundings and, at the same time as becoming instant 'experts', had to cope with nursing, reception and administrative staff who were strangers. 'What were they thinking about this new sex doctor. . ?' 'Had the doctor made it clear to Sister/Staff Nurse/Clinic Receptionist/Switchboard, etc. that no interruptions would be acceptable. . ?' 'Was the doctor clear as to how follow-up appointments for the patients would be arranged . . ?'

The doctor/patient relationship that the doctors had all come to respect and use as the intrinsic tool of our trade was suddenly threatened by the inter-personal relationship between the doctors and the clinic staff; the doctors and their peers in practice (in the Family Planning Clinic, in hospital

and general practice); even the relationship between the doctors and the leader and other members of the Seminar. Most of all, the doctors had on their minds the relationship with the referring doctor: there are extra pressures here, to help not only the patient but the referring doctor, too; and to build a reputation as a useful 'expert', in order to perpetuate employment as a psychosexual doctor.

For the first time these doctors were meeting referred patients with second-hand emotional problems. The intimacy of picking up a psychosexual problem in their own consulting rooms or on their own examination couches was missing. Their patients had told their stories to others doctors already. In the referral, part of the problem had been handed on, but written referrals are seldom able to relay the 'emotions' of the first encounter with the patient and the problem. Yet, all referring doctors had high expectations of the 'expert' doctor.

The patient, too, tends to have a different perception of an 'expert'. People are happy to share their feelings with a familiar, friendly and concerned doctor; but they have already tried that and have ended up with an 'expert' whom they expect to have the answers, which can be taken away from the clinic, to cure the ills: no sharing, here. So, the 'expert' in our field has to work much harder. The doctor starts from nothing, or less than nothing, to befriend the patient, to gain his or her confidence: to become a confidant(e).

Putting aside all the extrinsic influences in order to concentrate only on the doctor/patient relationship was beyond all these doctors at the beginning of their careers as 'experts'. It left at least one longing for a "nice, straightforward, female non-consummation", but in our practice nothing is straightforward; and if it seems too easy, we are left wondering what we have missed.

The three doctors continue to work in their respective clinics, less daunted by the pressures upon them and grateful for the constructive criticism, support and encouragement that they draw from the whole group at the Islington Advanced Seminar.

Dr. Keith Stewart, I.P.M. Associate
with
Dr. Caroline Albiston and
Dr. Sonia Robertson, I.P.M. Associate

EVALUATION OF PSYCHOSEXUAL NURSE SEMINARS BY A GROUP MEMBER, 1984—86

Following Jane Selby's letter in the May 1987 Newsletter, this report should be of interest to members.

To demonstrate the value of psychosexual seminars to those who participate in them, it is important to remember the extended role of the Family Planning (F/P) nurse in this field.

Anyone within the nursing profession will encounter patients with

psychosexual problems: knowing how to interpret and be of help is where the seminars are of use. For the patients, psychosexual problems represent misery, shame, failure and a sense of helplessness. Seeking help is often the most insurmountable problem. Trying to work with these patients/clients can leave the nurse feeling de-skilled. unnerved and drained. Because of taboos which still surround sex in our society, even terminology can become a problem. The Family Planning Clinic is frequently the place where help for these problems is sought. Not all Family Planning nurses find themselves able to undertake this work, but those who do try, acquire with experience, a heightened awareness and an ability to approach the patient at the patient's own level and work with him/her.

It may sound simple, but for many, psychosexual training is the most difficult they have undertaken. Some nursing practices have to be unlearned. Practical advice has little place; instead, the development of listening skills, an ability to sympathise with their pain, and then to use the feeling generated in oneself to help the patient to recognise and own her problem, and to work towards a solution, if possible. It is frequently found that the 'moment of understanding' for both nurse and patient comes at the time of vaginal examination.

Nurses working in this field need to bring to the patient a comfortable ability to listen, and to talk about things which the patient has previously found 'unspeakable'. This can range from extreme ignorance, loss of libido, vaginismus, worry over a discharge, etc., to rape, incest and molestation. The need for nurses to have support from their peer group is of incalculable value.

At the start of seminar training, most nurses feel inadequate, but usually a group becomes well knit, getting to know the strengths and weaknesses of its members, although some may find it too painful to continue. The learning process is enhanced in an atmosphere of trust and friendship, and we hope that even difficult criticism can be accepted. We constantly learn from our patients, and from sharing with the seminar group. With time and experience we become more confident, and realise that our contributions at the seminars are helpful to other members. It is often hard to recognise that there is no magic wand to wave over problems.

Obviously the development of a good group is not an accident. The essentials are eager participants and a skilled group leader. The current psychosexual seminar group for nurses in Winchester has now completed three years, with some losses and additions. During this time the leadership has changed and it has been interesting to observe the different styles of the two group leaders.

Initially in 1984-85 we were led by Doreen Clifford, and our present group leader is Margaret Taylor, one of our colleagues in Family Planning. Commitment of the group to their seminar work is vital, and all the members regard it as sufficiently important to attend in their own time, without payment.

S. Conway, S.R.N.

NOTICES

PANEL PASSES, May 1987

The following doctors have passed the panel of assessment and are now accredited and full Members of the Institute of Psychosexual Medicine:

Dr. Rosemary A. Bradbury,
Common Side Farm, North Lane, Cawthorne,
Barnsley, S. Yorks. S75 4AP

Dr. Helen C. Hutchinson,
60 Windsor Road,
Cambridge CB4 3JW

Dr. Margaret Wheatley,
Valley View, Canada Lane,
Caister, Lincs. LN7 6RN

THE ACCREDITATION PANEL

Doctors wishing to present their work for assessment should write to: The Panel Secretary, Institute of Psychosexual Medicine, 11 Chandos Street, Cavendish Square, London W1M 9DE.

The next two meetings of the Panel will be at the above address on 18th November 1987 and in May 1988.

The Panel currently consists of:

Dr. M. Gill (Secretary)
Dr. Alexandra Tobert
Dr. Robina Thexton
Dr. Gill Hinshelwood
Dr. Shelagh Lucas (Reserve).

FROM THE CHAIRMAN

Following the meeting of Council in June 1987, I am pleased to announce some changes in the senior scientific officers of the Institute.

Dr. Tom Main has accepted the post of Life President, and has generously agreed to continue to act as Consultant in Training for as long as he is requested to do so.

Dr. Prue Tunnadine, as Director of Training, has given unstinted service to the Institute over many years, and in recognition of this service and the volume of work it has involved, Council has decided to create the new post of Scientific Director. We are delighted that Dr. Tunnadine has agreed to accept this post.

On the recommendation of these two officers, Council has appointed Dr. Robina Thexton, one of our most experienced advanced leaders, to the post of Director of Training. We are very grateful to Dr. Audrey Jones, who has acted as senior administrative assistant to the Director of Training over the last year, for agreeing to continue in this essential post.

Ruth Skrine

JOB OPPORTUNITIES

A vacancy exists for a doctor for Psychosexual Counselling for the Family Planning Service in Basingstoke, for one session a week.

This post became vacant when the previous counsellor retired. It was advertised locally and in the British Medical Journal but no applications were received.

The session was previously held on Monday afternoon, but this could be altered.

If anyone is interested in this session, perhaps they would telephone Basingstoke 473202 ext. 5930 for further details.

Although there are non-medical psychosexual sessions run in the District, it would be a great pity to let this particular part of the service lapse.

Community Care Unit
Harness House, Park Prewett,
Basingstoke, Hants.

Worcester and District Health Authority — Psychosexual Service

A vacancy exists for a doctor holding the Certificate of the Institute of Psychosexual Medicine for the Psychosexual Service at Moor Street Clinic, Worcester.

At present, the Clinic is held on a Tuesday morning from 11.30 a.m. — 1.00 p.m. However, the Clinic could be held on another day by arrangement, or on Monday, Tuesday or Wednesday evening.

If distance is a problem, two sessions could be held on one day, once a fortnight. The doctor would be graded as Senior Clinical Medical Officer, on the appropriate scale.

Applications to:
Dr. M.J. Windsor, Senior Clinical Medical Officer,
Family Planning Department, Moor Street Clinic,
Moor Street,
Worcester WR1 3DB
Tel. (0905) 21075, ext. 143.

BRITISH JOURNAL OF FAMILY PLANNING

Members are invited to submit articles on psychosexual work. They will be published if of a high enough standard. Dr. Forsyth is willing to offer advice or criticism about acceptability.

It is hoped that some members will submit papers in order to make closer links between the I.P.M. and N.A.F.P.D.

OBITUARIES

Dr. M. Lois Blair

We record with sadness the death of Dr. M. Lois Blair, I.P.M. Member.

Dr. Joe Brown

It is with sadness that we record the untimely death of a Founder Member, Joe Brown, on 27th April 1986. Joe Brown was born in a Lancashire mining village on 9th December 1923, worked down the mines while he took his school certificate and trained as a teacher; then, working as a teacher, he qualified as a dentist in 1956. With his wife's agreement they abandoned the prospect of having children. He started at King's College Hospital, while working as a dentist, and finally qualified in 1961. He went on to gain the D.R.C.O.G., the D.P.H. and became an M.F.C.M., while occupying the post of S.H.O. at Queen Charlotte Hospital and Junior Lecturer in Physiology at Guys Hospital. He joined Dr. Jean Pasmore's seminar and was a founder member of the I.P.M.

I got to know Joe well after he had volunteered to join the research group which published the Prospective Study of the Treatment of Non-consummation. During the arduous monthly meetings — deciding on the form of the study, applying for grants, the carrying out and analysing of the work — Joe was a regular and hard-working colleague. His particular responsibility was searching for references and copying and distributing relevant papers. Joe always brought his own original talent to our deliberations and continued to be cheerful and undaunted when our task seemed overwhelming.

During his latter years he was working as S.C.M.O. in Community Health in Ipswich. He ran a family planning clinic right beside the bus stop, so that it was easily available. Recently I met a woman in her early thirties who spoke with affection of Joe and the help that he had given to the young people of Ipswich and the surrounding county. He also gave his support to local boys' clubs, which was typical of his generous nature.

He was also immensely kind and supportive in personal relationships and he and his wife cared for both of their elderly sick parents in their home. He leaves a widow to whom we send our condolences.

Katharine Draper
I.P.M. Member

IN PRESS

Skrine, R.L. (Ed.). *Psychosexual Training and the Doctor/Patient Relationship. (Institute of Psychosexual Medicine Digests I.).* Published by Montana Press, P.O. Box 67, Carlisle CA4 9DE. 392 pages. £17-50 + £1-50 p. & p. = £19-00. Due for publication in mid-October 1987.

FROM THE JOURNALS

D.K. McCulloch, D.J. Hosking, A. Tobert (Nottingham). *A pragmatic approach to sexual dysfunction in diabetic men: Psychosexual counselling.* Diabetic Medicine, Vol. 3, 1986, 485-489.

Twenty diabetic men with impotence were treated with psychotherapy; the improvement in three could not be predicted by their pretreatment characteristics. Most of those entering the trial had been impotent for several years and had adapted to their loss (although requesting treatment). This emphasised the need for early detection and help. The extensive neurological and vascular investigations which may be undertaken in specialised units is unlikely to lead to either a definitive explanation of the cause of impotence, nor (of more importance to the patient) to rational physical treatment. Early psychosexual counselling may obviate the need for such investigation and prevent the establishment of defensive adaptive mechanisms.

D.M. Ndetei and E.G.M. Wazome. *Experiences from a marital-sex therapy clinic in Nairobi.* Acta psychiatr. scand. 1986. 74: 479-484.

This pioneer clinic in Kenya was flooded with referrals and personal requests to be seen within a short time of opening. In a closer look at 52 of the first 100 patients seen there was a preponderance of young males. The problems were perceived by the patients as being of physical origin but purely psychological factors were found in nearly 90%. There was a similar pattern of sexual problems to those seen in clinics with a western setting, but the factors sustaining the sexual dysfunction appeared to be less subtle and more susceptible to intervention.

L.J. Freeman and J.C. King. *Sex and the post-infarction patient.* Cardiology in practice. 1986 Nov. 6-8.

Counselling patients after a heart attack about sexual activity should be a normal part of the rehabilitation programme but even the few physicians (35%) who did include this spent less than five minutes discussing it. Ignorance about the effects of sexual activity on the body is widespread and some of the facts and myths are examined in this article. For example, the risk of sudden death during intercourse is less than the risk of being struck by lightning and the rise in pulse rate during intercourse is about the same as that recorded while driving a car. Facts to dispel the myths need to be presented to patients and their partners to prevent anxieties and avoidance of sexual activity.

Patricia d'Ardenne. *Sex Therapy Education in a Medical College.* Sexual and Marital Therapy, Vol. 1, No. 2, 1986.

Workshops in the London Hospital consisting of six hours of teaching time, which included written notes, a video, a lecture, role-play and discussions, were offered to groups of about 18 students over a three-year period. Assessment was made using a questionnaire and inviting comments. Many of the students complained that the workshop had come too early in their clinical teaching and many of them were unable to decide whether the course

was appropriate to their needs. The primary aim of the workshop was to raise awareness of sexual problems and a further questionnaire is being prepared to follow the students of 1979-1982 to discover whether these students had developed a greater interest and expertise in the subject after leaving medical school.

NEW MEMBERS AND ASSOCIATES

NEW MEMBER

Dr. A. Margaret Lloyd	Old Cottage, Church Street, Crondall, Farnham, Surrey GU10 5QQ

NEW ASSOCIATES

Dr. Rowena Bennet	13 Waldridge Road, Chester-Le-Street. Co. Durham DH2 3AB
Dr. S. Jane Bowman	5 Denewell Avenue, Low Fell, Gateshead, Tyne & Wear NE9 5HD
Dr. J. Brophy	27 Station Road, Waterbeach, Cambridgeshire
Dr. Rose de Boer	17 Enmore Gardens, East Sheen, London SW14 8RF
Dr. Margaret Denman	22 Brandling Park, Jesmond, Newcastle upon Tyne NE2 4RR
Dr. Alyson J. Elliman	2 South Rise, Carshalton Beeches, Surrey SM5 4PD
Dr. Susan Grieve	55 Richmond Avenue, Highams Park, London E4 9RR
Dr. Sylvia Inglis	23 Hyland Close, Hornchurch, Essex RM11 1DX
Dr. Jacqueline M. James	86 Ranby Road, Sheffield
Dr. Claire Kane	Flat 3, 15a Courtfield Road, London SW7 4DA
Dr. Elizabeth A. McHenry	216 Friern Road London SE22
Dr. Fadha Shinewi	38 St. Faith's Road, West Dulwich, London SE21 8JD
Dr. Angela Stewart	15 Park Road, Winchester, Hants. SO22 6AA
Dr. Margaret A.W. Sutton	3 Danesdale Road, London E9 5DB
Dr. Marilen G. Wakeling	59 Bishopthorpe Road, Sydenham, London SE26 4PA
Dr. Anne Worrall	24 Moor Lane, Bramcote Hills, Nottingham NG9 3FH

CHANGE OF ADDRESS

Dr. Raymond E. Goodman	13 Drayton Manor, 507 Parrswood Road, Didsbury, Manchester M20 0GJ
Dr. S. Toogood	District M.O., Dudley Road Hospital, Birmingham

I.P.M. CURRENT TRAINING SEMINARS

BASIC SEMINARS

REGION	TERM	LEADER	PLACE
Northern	6th	Dr. A. Smith	Newcastle
Yorkshire	4th	Dr. J. Coombs	Bradford
	1st	Dr. D. Anderson	Hull
Trent	Ongoing	Dr. J. Tattersall	Sheffield
	Ongoing	Dr. S. Filshie	Nottingham
East Anglia	7th	Dr. B. Devereux	Norwich
	1st	Dr. R. Thexton	Cambridge
	1st	Dr. R. Lincoln	Bury St. Edmunds
N.E. Thames	1st	Dr. R. Sampson	Finchley
	4th	Dr. S. Lucas	Romford
S.E. Thames	3rd	Dr. A. Jones	Bromley
N.W. Thames	1st	Dr. M. Gill	St. Albans
S.W. Thames	4th	Dr. S. Horsewood-Lee	Wimbledon
	Ongoing	Dr. T. Main	Sharpethorne
S. Western	3rd	Dr. J. Tisdall	Plymouth
	Ongoing	Dr. G. Wakely	Bristol
W. Midlands	6th	Dr. S. Snead	Birmingham
	Ongoing	Dr. H. Backer	Gloucester
Mersey	2nd	Dr. S. Snead	Chester
Wales	Ongoing	Dr. H. Backer	Swansea

Further seminars are being planned for Brent, Leeds, Maidstone and Manchester.

CONTINUATION SEMINARS

Norwich	Dr. B. Devereux
Plymouth	No leader

ADVANCED GROUPS

Newcastle	Dr. R. Freedman
Islington	Dr. P. Tunnadine
Hammersmith	Dr. T. Main
Sheffield	Dr. M. Bramley
Southampton	Dr. R. Thexton

OTHER GROUPS RUN BY I.P.M. LEADERS

Ipswich	Nurses	Dr. R. Lincoln
Bath	Physiotherapists (Obstetric)	Dr. R. Skrine
Cambridge	Nurses	Dr. R. Thexton

REGIONAL TRAINING CO-ORDINATORS

Northern	Dr. A.V. Smith	6 The Crescent, Longbenton, Newcastle upon Tyne NE7 7ST Tel. Newcastle upon Tyne 66254
Yorkshire	Dr. D. Anderson	4 Newstead Road, St. Johns, Wakefield, Yorks. WF1 2DE Tel. 0924 372836
Trent	Dr. S.E. Filshie	2 Pembroke Drive,Mapperley Park, Nottingham NG3 5BG Tel. Nottingham 625632
E. Anglia	Dr. R.D. Lincoln	67 Yarmouth Road, Norwich NR7 0EW Tel. 0603 31628
N.W. Thames	Dr. J. Kilvington	122 Marshalswick Lane, St. Albans, Herts. AL1 4XD Tel. 0727 53156
N.E. Thames	Dr. J. Gilley	42 Avondale Avenue, London N12 8EN Tel. 01-445 1654
S.E. Thames	Dr. A.J. Jones	1 Minshull Place, Park Road, Beckenham, Kent BR3 1QF Tel. 01-658 6185
S.W. Thames	Dr. R. Thexton	41 Hillcroft Crescent, London W5 2SG Tel. 01-997 1748
Wessex	Dr. Mary Thomas	Cliff House, Cliff Way, Compton Down, Winchester, Hants. SO21 2AP Tel. 0962 712183
Oxford	Dr. J.E. Rogers	11 Turners Road, Slough, Buckinghamshire Tel. 0753 22495
S. Western	Dr. R. Skrine	Castanea House, Sham Castle Lane, Bath BA2 6JN Tel. 0225 65440

Devon & Cornwall	Dr. J. Tisdall	23 Furzehatt Road, Plymstock, Plymouth, Devon PL9 8QX Tel. 0752 42356
West Midlands	Dr. S.M. Snead	30 Church Road Lilleshall, Shropshire Tel. 095 284 4560
Mersey/N. Western	Dr. M. Upsdell	85 Church Road, Woolton, Liverpool L25 6DB Tel. 051 428 5637
Wales	Dr. D.A. Morgan	The Gables, Llangenny Lane, Crickhowell, Powys Tel. 0873 810176
N. Ireland	Dr. J.G. Neill	42a Cadogan Park, Belfast, N.I. BT9 6HH Tel. Belfast 662861

INSTRUCTIONS TO CONTRIBUTORS

Articles on all aspects of the work in psychosexual medicine are welcomed for publication in the Newsletter. Manuscripts should be typed on one side of A4 paper, double-spaced and with wide margins. Pages should be numbered.

The first page should include the title, the name and qualifications of the authors and their appointments. Each page should bear the title and author's initials. Please send two copies. Patients' names, locations, jobs and other identifying features should be disguised.

Letters to the Editor are welcome. Correspondents should state their qualifications and address.

Contributions for the May 1988 edition should reach the Editor by 31st March 1988, preferably much sooner. The address is: Greenhills, Back Lane, Hathersage, Sheffield S30 1AR.